Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2020	2020_650565_0011	003560-20, 004308-20, 017119-20, 018171-20	Complaint

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

Long-Term Care Home/Foyer de soins de longue durée

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 28-30, October 1-2, 5-9, and 13, 2020.

The following intakes were completed in this complaint inspection:
Log #003560-20, Log #004308-20, Log #017119-20, and Log #018171-20 were related the care given to residents and the operations of the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Dietary Supervisor (DS), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, and Family member.

During the course of the inspection, the inspector observed resident and staff interactions, and reviewed clinical health records, home policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that sets out the planned care for the resident.

The resident had demonstrated responsive behaviours and one of them was more frequent during a several-month period.

The home had put in place the care to manage this behaviour, but the resident's written plan of care did not set out this planned care for the resident.

The resident’s behaviour was further assessed by the outside resource team and they recommended another care for this behaviour. The written plan of care did not set out the use of this recommended care for the resident.

Sources: Resident’s progress notes, assessment records, care plan, and Documentation Survey Report v2; observations; interviews with family member and staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for a resident that sets out clear directions for using the as needed medication to staff and others who provide direct care to the resident.

The resident’s plan of care stated they had an order for a medication as needed. The physician order did not set out clear directions for what condition indicated the use of the

medication.

The resident's family member inquired to the home for the use of the above-mentioned medication for a specified condition. As a result, the team consulted with the physician and determined to administer the medication to the resident for such condition. The physician's order for the medication was not revised to set out clear directions when it was as needed for the resident.

Approximately two weeks later, the team considered using the same medication for other conditions. There was no clear direction setting out when to use the above-mentioned as needed medication for the resident.

Sources: Resident's Electronic Medication Administration Records, physician orders, care plan, progress notes; interviews with family member and staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the provision of the individualized menu set out in a resident's plan of care was documented.

The resident was recommended with a specified food diet after a medical procedure and the home had started an individualized menu to meet the resident's care needs.

The home used the dietary preference list, People Service Report, to set out all residents' current dietary restrictions and individualized menus, but they did not have the documentation for the individualized menu that was provided to the resident during that time. The resident's progress notes and assessment records indicated certain food items had been given to the resident after the medical procedure, but no records documented what individualized menu was provided, when it was started and ended for the resident.

Sources: Resident's People Service Report, progress notes, dietary referrals and assessments, care plan; interviews with staff. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- there is a written plan of care for each resident that sets out 1) the planned care for the resident, and 2) clear directions to staff and others who provide direct care to the resident;
- the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that a RPN used safe transferring and positioning techniques when assisting a resident.

The RPN performed a care to the resident. During the care, the RPN did not use the safe transferring and positioning techniques to assist the resident when they sat down on a chair. As a result, the resident lost balance and fell.

Sources: Resident's progress notes, Post-Fall Incident Form, and Risk Management falls incident notes; interviews with staff. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for a resident demonstrating responsive behaviours, actions including assessments and reassessments were taken to respond to the needs of the resident.

The resident had demonstrated responsive behaviours and one of them was more frequent during a several-month period.

The resident was assessed and reassessed by the outside resource team related to their behaviours. For the behaviour that became more frequent, it was not brought to their attention for assessment until approximately five months later. The home had not taken actions that included assessments and reassessments to respond to the needs of the resident during this period.

Sources: Resident's progress notes, assessment records, and Documentation Survey Report v2; interviews with family member and staff. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident include assessments, reassessments and interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident with the following weight changes were assessed using an interdisciplinary approach:
- A change of 5 per cent of body weight, or more, over one month
- A change of 7.5 per cent of body weight, or more, over three months
- A change of 10 per cent of body weight, or more, over 6 months

The resident's weight records indicated they had four significant weight changes occurred after they received a medical procedure. These weight changes for the resident should have been assessed using an interdisciplinary approach, and they were not.

Sources: Resident's dietary referrals and assessments, progress notes, weight records; interview with staff. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident with the following weight changes were assessed using an interdisciplinary approach:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 month, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Fall Prevention & Management Program policy included in the required Falls Prevention Program was complied with for a resident.

O. Reg 79/10, s. 30 (1) 1 requires each of the interdisciplinary programs required under section 48 of this Regulation to comply with the following: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

O. Reg. 79/10, s. 48 (1) requires that a falls prevention and management program is developed and implemented in the home to reduce the incidence of falls and the risk of injury.

The resident fell when a RPN assisted them during the care. The home's falls prevention and management program policy stated the DOC will lead and coordinate the implementation of the program, and the nurse will complete a post-fall assessment using the Post-Fall Incident Form. Interviews with the DOC and other staff indicated the falls prevention program directed the registered staff to complete the Post-Fall Incident Form in the Point Click Care as soon as possible during the shift that the resident fell. The Post-Fall Incident Form for the resident's fall incident was not completed until two days after the fall.

Sources: Home's falls prevention and management policy; resident's progress notes and Post-Fall Incident Form; interviews with staff. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint made to the licensee or a staff member concerning the operation of the home was dealt with as follows:
- For those complaints that cannot be investigated and resolved within 10 business days, a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

A complaint was made by a family member to the home concerning the operation of the home. The home met with the family member within 10 days for a follow-up but the home's investigation was not completed, and the complaint was not resolved at that time. The home had not notified the family member the date by which they can reasonably expect a resolution.

Approximately 12 weeks after the complaint, the family member contacted the home to follow-up. The home did not respond to the family member until after they were contacted.

Sources: Home's complaint and investigation records; email complaint sent by the family member; interviews with the family member and staff. [s. 101. (1) 2.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

The resident was prescribed with a drug at bedtime. On one night, the drug was administered to the resident approximately three and a half hours later than the scheduled time. Staff interviews indicated they had no recollection on why it was administered late but not in accordance with the directions specified.

Sources: Resident's Medication Administrative Audit Report, care plan; interviews with staff. [s. 131. (2)]

Issued on this 17th day of November, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.